

## Maurer School of Law: Indiana University Digital Repository @ Maurer Law

Articles by Maurer Faculty

Faculty Scholarship

2015

# Conceiving of Products and the Products of Conception: Reflections on Commodification, Consumption, ART, and Abortion

Jody L. Madeira

*Indiana University Maurer School of Law, [jmadeira@indiana.edu](mailto:jmadeira@indiana.edu)*

Follow this and additional works at: <http://www.repository.law.indiana.edu/facpub>



Part of the [Bioethics and Medical Ethics Commons](#), and the [Medical Jurisprudence Commons](#)

### Recommended Citation

Madeira, Jody L., "Conceiving of Products and the Products of Conception: Reflections on Commodification, Consumption, ART, and Abortion" (2015). *Articles by Maurer Faculty*. Paper 2050.

<http://www.repository.law.indiana.edu/facpub/2050>

This Article is brought to you for free and open access by the Faculty Scholarship at Digital Repository @ Maurer Law. It has been accepted for inclusion in Articles by Maurer Faculty by an authorized administrator of Digital Repository @ Maurer Law. For more information, please contact [wattn@indiana.edu](mailto:wattn@indiana.edu).



**LAW LIBRARY**  
INDIANA UNIVERSITY  
Maurer School of Law  
Bloomington

---

# Conceiving of Products and the Products of Conception: Reflections on Commodification, Consumption, ART, and Abortion

*Jody Lyneé Madeira*

“A good wit will make use of any thing: I will turn diseases to commodity.”

Sir John Falstaff,  
King Henry IV, Part II, Act I, Scene II

## Introduction

Thorny and difficult questions permeate the issue of commodification of assisted reproductive technologies (ART) and abortion. Are ART and abortion services or medical treatment? Are those who seek them patients or consumers? How should we understand the complex relationship between money, markets, choice, and the care relationship?

This paper rejects the dichotomy between patient and consumer roles and focuses instead on how attributes of each are meaningful to those seeking health care. Arguing that health care is already commodified, it suggests that both medicine and the market offer strategies for handling commodification. The important questions are how we understand these attributes and their role in care relationships, and which attributes we should encourage. The medical profession and patient role have long accommodated commodification, using fiduciary roles, flat fees and opaque pricing to distance payment and pricing from care provision. In contrast, the market and consumer role emphasize choice and consumer agency, arms-length transactions, and exchange for value. To avoid the dehumanization of the commodification critique, health care can be restructured to combine elements of both patient and consumer choice models.

The first step is to untangle two discourses usually positioned as contradictory and competing: patient vs. consumer and commodification vs. non-commodification. Social science research shows that “patient” and “consumer” are not useful to most care-seekers, the vast majority of whom define themselves as patients. Rather, these terms are umbrella concepts that stand for several attributes — agency, responsibility, communication, compassion, and so on. By identifying as a “patient” or a “consumer,” care-seekers signal what attributes are important, and in what degree (e.g., how they prefer providers to display empathy, and how important that attribute is compared to others). The ideal care relationship merges the attributes of both the patient and consumer roles that they subjectively judge “best” — high communication, high empathy, high choice, medium agency — rendering the distinction between the patient/consumer roles unimportant.

---

**Jody Lyneé Madeira, J. D. Ph.D.,** is Professor of Law and Louis F. Niezer Faculty Fellow at the Maurer School of Law at Indiana University Bloomington.

Commodification also impacts reform. Scholars usually focus on the market/altruism dichotomy, on whether or not a price is charged, and perhaps on the doctor-patient relationship. But commodification's positive and negative aspects come not from the doctor-patient relation or payment of fees but from the physician's orientation to her role and to other doctors — how doctors judge success, and what medical enterprises are organized to achieve. Interestingly, the “best” physicians and clinics are not non-commodified, but redefine commodified care. They do not try to escape the market or work against it, but use it to streamline services without sacrificing care.

unequal because patients lack equal power, status, and knowledge and therefore depend upon doctors, who attempt to heal but may inadvertently harm. This relationship may include compassion and trust, “openness and respect,” but also authoritarianism and paternalism.<sup>5</sup> The law acknowledges patients' vulnerability by creating a protective rights scheme, creating a fiduciary doctor-patient relationship in contrast to the “caveat emptor” consumer standard.<sup>6</sup>

In contrast, both in health care and in commerce more broadly, consumer implies a transaction in which service is exchanged for payment. A consumer experiences services or ingests products.<sup>7</sup> The term

**This paper rejects the dichotomy between patient and consumer roles and focuses instead on how attributes of each are meaningful to those seeking health care. Arguing that health care is already commodified, it suggests that both medicine and the market offer strategies for handling commodification. The important questions are how we understand these attributes and their role in care relationships, and which attributes we should encourage.**

In Part I, this essay defines the roles of patient and consumer, and then describes how they are ultimately less important than the attributes of which they are comprised. In Part II, it describes theories of commodification and consumption in reproductive contexts and their negative and positive consequences, from compliance and coercion to resistance and creativity. It also examines whether ART and abortion are “markets,” when, and with what effects. In Part III, this essay explores how the attributes which comprise the patient/consumer roles can be incorporated into health care reform, and the implications that various health care reform models would have for ART and abortion.

### **Beyond the Patient/Consumer Dichotomy**

#### *Redefining Patients and Consumers*

Derived from the Latin “*patiens*” (“to suffer” or “to bear”), a patient is often characterized in social science and popular culture as sick, vulnerable, having few if any choices, and passive.<sup>1</sup> On one hand, the term may trigger stigma, abnormality, or even neuroticism; on the other, it can initiate therapeutic relationships.<sup>2</sup> “Patient” may not accurately describe “healthy” individuals who seek preventative care, advice, or elective services, and it can imply patient passivity and provider omniscience.<sup>3</sup> A patient is in a “thick” relationship with an alter ego — a care-provider or physician.<sup>4</sup> This relation is inherently

“consumer” can empower, infuse normality into stigmatized and subordinated experiences and identities, decrease paternalism and demedicalize care roles and relationships.<sup>8</sup> It might better fit healthy persons seeking preventative care or advice.<sup>9</sup> Moreover, “consumer” connotes rationality, vocality, and choice over products and uses.

Ideally, a health care consumer weighs medical costs against perceived benefits and obtains care from the “best value” provider.<sup>10</sup> As market creatures, consumers are active in health care decision-making, armed with information, confidence, assertiveness, and the rights to demand treatment access, options, providers, and desires.<sup>11</sup> Unlike patients, consumers need not be in relationships with physicians at all; if they are, the relationship is arms-length, like “businessman-customer,” and connotes financial remuneration, commerce and industry, and the “generic contractual aspects of a standardized professional service.”<sup>12</sup> Premised on an economic-legalistic rather than moral-ethical framework, this relation emphasizes “efficiency, profit maximization, consumer satisfaction, ability to pay, planning, entrepreneurship, and competitive models.”<sup>13</sup> The commercialization of “consumer” inspires discomfort or even visceral dislike in most care professionals, for whom it trivializes the care relationship and renders professionals entrepreneurs.<sup>14</sup>

Mining these role descriptions reveals stark disparities. Patients are supposedly unwell, in need, vulnerable, passive, devoid of agency and choice, stigmatized, lack control, and in an inherently unequal treatment relationship. In relationships with care professionals, patients seek compassion, trust, openness, respect, information, competence, and guidance; paternalism may even be expected or welcomed. Health care consumers, on the other hand, are allegedly competent, rational, independent, active, assertive, informed, free to choose services and providers (or walk away). They have purchasing power, and are not necessarily in a treatment relationship (again, this portrait contrasts with the vulnerable consumer within consumer protection). In treatment relations, consumers seek value and competence. From this perspective, the patient and consumer roles appear locked in a contest between “haves” and “have-nots.” Both roles seem too extreme to encapsulate care-seekers’ lived experiences, but strand most in the messy middle.

But if we look past labels to what “makes” a patient or consumer, we can see that they are comprised of several attributes which individuals may feel are more or less important for them to adopt in their relationships with care providers: self-capacity, control, agency, advocacy, and choice or opportunity. Similarly, most care seekers will prioritize certain qualities in “good” care provider relationships: trust, openness, compassion or sensitivity, respect, communication (including information and dialogue), continuity, commitment, competence, and affordability. These attributes become important because we cannot “inspect” service quality before treatment and must negotiate uncertainty through a “generalized belief in the ability of the physician.”<sup>15</sup> Of course, certain attributes are more important given individual preferences, needs, or treatment contexts. For example, building trust in ART, where women usually make several visits to one provider, will be different than in abortion, where most make one or two visits.

Focusing on the attributes that comprise the patient and consumer roles overcomes the many limitations of regarding these roles as a dichotomy. It avoids semantic puzzles and reflects that “the roles of doctor/provider and patient/consumer are hard to disentangle.”<sup>16</sup> It explains our discomfort over “consumer” and our urge to preserve what seems valuable about “patient.” It rescues us from comparisons between those “ill and seeking help” and those “purchasing a pair of socks or a pound of sausages.”<sup>17</sup> These attributes become unique goods inherent in medical ideology and care relations, comprising the “care” in the care relation. They help determine care-seekers’ provider satisfaction, make care experiences feel less or non-commod-

ified, and are tools for demanding “better” care. Care-seekers think in terms of these attributes, not in terms of patient and consumer roles. Ideally, these attributes themselves become goods that care-seekers and providers exchange within relationships, and for which many may willingly pay higher costs. Moreover, this approach means that care seekers and providers are not restricted to one “role” within the relationship, but have the freedom to prioritize certain attributes over time and in response to developments in the treatment relationship.

By themselves, “patient” and “consumer” labels give little information about care-seeker behaviors, or whether they are helpful or problematic. But focusing on role attributes gives us an exponentially more detailed experiential view, allowing us to assess and remedy specific harms rather than judging care-seekers to be failing as patients or consumers. We can most effectively improve care experiences by prioritizing different attributes.

The patient/consumer debate has, however, provided guidance on which attributes are most important. Most social science scholars and commentators prefer “patient” because of care-seekers’ vulnerability, relational dependence, patient rights and the term’s emphasis on beneficence (versus autonomy), the doctor-patient relation, and its emphasis on partnership over mere choice.<sup>18</sup> Unsurprisingly, most care-seekers surveyed (and often the vast majority) see themselves as “patients”<sup>19</sup> — a proxy for expressing comfort with a certain attribute bundle over others. Focusing on the attributes comprising patient and consumer roles frees us from purchasing a role “package” or engaging in debates over role superiority. Moreover, these attributes play key roles in how care-seekers negotiate reproductive commodification within ART and abortion, refocusing on the humanity of a treatment experience situated within the market.

### **From Reproductive Commodification to Reproductive Creativity and Beyond**

Debates over patient and consumer roles become more complex when mapped onto questions of how markets and commodification affect ART and abortion. This essay argues that reproductive health care is inherently commodified. Therefore, it focuses primarily on how we negotiate and experience commodified reproductive care. Focusing on which attributes care seekers prioritize is critical. Care seekers earmark these attributes as significant based on their experiences within a commodified treatment environment, and can guide reforms. If it is good for business to focus on these attributes in all care environments, these attributes will become available to care-seekers

of all socioeconomic statuses. Hence, commodification can benefit, not just burden, those least well off. Thus, just as we rejected the patient/consumer dichotomy, we must push beyond the commodification/non-commodification dichotomy to focus on how these attributes are present in consumer experience and affect providers' orientation to care seekers, colleagues and practice areas.

### *Reproductive Commodification, Consumptive Creativity*

Commodification refers to “the economic and cultural processes” through which objects become marked as commodities, and their consequences.<sup>20</sup> Goods or services become commodities — things to be exchanged for value — by acquiring exchange and use values in a marketplace.<sup>21</sup> Commodities are external to people, and may seem like alien objects in commercial space, “cold and sterile” entities that functionally serve human needs and can be manipulated.<sup>22</sup> But our relationships with commodities may change; once acquired, commodities can be appropriated and personalized. Commodification and commodities acquire value through consumption, “the purchase and use of goods, services, materials, or energy.”<sup>23</sup>

Problems arise when comparing objects that can be valued in different ways, such as shoes and sex; while some argue that both can have monetary value, others would object to putting a price on sex. “Both pro- and anti-commodification camps” tend to “frame discussions in terms of an on-off decision about whether or not to commodify,” so that the “discussion [] follows fixed rails, forever trying to pinpoint the proper boundary between market and nonmarket transactions.”<sup>24</sup> Others have argued that there are degrees of commodification, from universal, to incomplete or partial to no commodification.<sup>25</sup>

Opposition to reproductive commodification produces strange bedfellows. Both conservatives and liberals co-opt commodification discourse supporting certain “protective” restrictions or improved conditions in abortion and ART. Barred from shutting down abortion markets entirely (under the “undue burden” standard in *Planned Parenthood v. Casey*), conservatives want to impose market constraints presented as choice architecture.<sup>26</sup> Basing regulations on “women-protective anti-abortion” reasoning, they support waiting periods, informed consent modifications, extended counseling, ultrasounds, clinic compliance with hospital building guidelines, restricted public funding and mandatory provider admitting privileges.<sup>27</sup> After the Missouri legislature extended a 24-hour abortion waiting period to 72 hours on May 13, 2014, “Missouri Right to Life” released a state-

ment asserting “[this bill] will save babies and protect all women...from abortion clinics seeking to make a profit on an abortion.”<sup>28</sup> Liberals also adopt consumer rhetoric, but to preserve choice, stressing women’s “right to choose,” access to “safe” abortion, or “abortion on demand.” One advocacy guide advises “consumer demand is a powerful tool for change” and asserts that “women — the consumers or primary beneficiaries of safe abortion — can have a strong effect on many aspects of health care by demanding change.”<sup>29</sup>

Reactions to commodification and consumption have changed over time. Theorists have long disagreed over how commodification affects human potentials for creativity and identity-formation. Early economic approaches such as Marxism posited that workers became alienated from their labor when consuming goods, transforming social relations into relations between things.<sup>30</sup> For Frederic Jameson and the Frankfurt School, such market relations manipulated consumers into satisfying producers’ needs and generating profits.<sup>31</sup> Similarly, reproduction has been analogized to industrial factory production, with pregnancy as factory floor, the uterus as baby-producing machine, the pregnant woman as laborer, the doctor as foreman dedicated to a production schedule and fetuses as commodities.<sup>32</sup>

The Chicago School and law and economics movements embraced universal commodification — a market for everything.<sup>33</sup> Most since then oppose universal commodification,<sup>34</sup> targeting the parent/surrogate-children and donor/patient-physician relationships. Addressing egg donation, surrogacy, prenatal testing and preimplantation genetic diagnosis (PGD), scholars argue that women’s bodies and reproductive capacities, embryos, fetuses, and children should not be commodified, and warn that ART can coerce and exploit patients. They argue that it is impossible or unwise to monetarily value certain goods, that monetary valuation does not capture these goods’ significance, that valuation and exchange can warp those goods, and that transactions exchanging these goods for money are involuntary or accessed unequally.<sup>35</sup> Many of these arguments presume that intimate relations and economic transactions belong to “hostile worlds” or “separate spheres.”<sup>36</sup> Conflating these categories violates human dignity and moral worth; thus, Margaret Jane Radin has famously urged, some goods should be “market-inalienable.”<sup>37</sup> Similarly, Edmund Pellegrino argues health care is not a commodity since it “center[s] too much on universal human needs” and its effectiveness depends on interpersonal relations, not objects.<sup>38</sup> A commodified doctor-patient encounter may become “a commercial relationship” governed by commerce, torts, and contracts instead of profes-



sional ethics, fostering “profit-making and pursuit of self-interest.”<sup>39</sup>

But other scholars focus on how people create personal and social identity within commodified environments. Scholars have become more skeptical of anti-commodification arguments, observing that harm lies in how objects are used, and that such arguments create caricatures of coerced victims and commercial contractors.<sup>40</sup> Kimberly Krawiec asserts that anti-commodification arguments are elitist, “invoked for political gains” by groups whose interests are “at odds with broader social goals,” and observes that the problems they target often are unrelated to commodification.<sup>41</sup> Viviana Zelizer posits that “markets do not overrun cultures but are themselves defined and

markets “cannot persuasively rest on concerns over commodification and commercialization, as the market was commodified and commercialized long ago.”<sup>47</sup> The question then becomes how persons negotiate commodified reproductive contexts and with what consequences.

Consequently, our investigations into commodification and consumption must not stop at whether care seekers use treatments creatively or to modify self-identity, but must penetrate further into their lived experiences of these treatments. This is essential in ART and abortion, where care seekers’ first goal is attaining or terminating pregnancy, accomplishing something beyond altering self-identity. These treatment experiences are very different than, say, buying

our investigations into commodification and consumption must not stop at whether care seekers use treatments creatively or to modify self-identity, but must penetrate further into their lived experiences of these treatments.

This is essential in ART and abortion, where care seekers’ first goal is attaining or terminating pregnancy, accomplishing something beyond altering self-identity. These treatment experiences are very different than, say, buying designer jeans. Focusing on the treatment experience also provides insight into how people consume care services to complete self-identity projects (i.e., attaining or avoiding motherhood).

influenced by culture,” and that market transactions and intimate relations are inherently interdependent.<sup>42</sup> Martha Ertman explains how commodification can overcome barriers violating human dignity (e.g., extending reproductive options for gays and lesbians).<sup>43</sup> Ruth Fletcher’s theory of reproductive consumption focuses on how we “negotiate reproduction as a necessary human activity” that contributes to creativity and relationship-building and not merely profiteering.<sup>44</sup> ART and abortion, then, are contexts where care seekers negotiate “how best to understand and adjudicate the relationship between ‘persons’ and ‘things.’”<sup>45</sup>

This essay, too, is skeptical of anti-commodification arguments, and argues that they are passé because reproduction is already inherently and almost certainly intractably commodified. The very language that is the rallying cry for reproductive decision-making – choice – is more closely identified with the stereotypical consumer role. Reproductive decisions such as whether to freeze eggs or undergo IVF or adoption are at base decisions about consumption and distribution.<sup>46</sup> Thus, for Krawiec, objections to reproductive

designer jeans. Focusing on the treatment experience also provides insight into how people consume care services to complete self-identity projects (i.e., attaining or avoiding motherhood).<sup>48</sup> It is important to note that a treatment experience can only de-commoditize, *not* non-commoditize, reproductive technologies or services. Just because a care seeker does not feel like she has had a commodified treatment experience does not mean that the treatment ceases to be commodified. De-commodification does not end commodification; when goods or services are marked as “other than commodities,” other meanings attach despite commodification and become important because they contradict it.<sup>49</sup>

#### *B. ART and Abortion as Sites of Consumerism and Commodification*

Assessing ART and abortion as commodified services implicates reproductive choice. Sometimes, choice is illusory; we make decisions in response to felt needs, lack of viable options, or cultural imperatives. Undergoing IVF, for instance, reaffirms cultural ideals of persistence and effort.<sup>50</sup> Choice also connotes

cultural decision-making norms favoring rationality and reflection as well as the specter of mistake, and therefore invites consumer-protection measures. The “distinctive and crucial feature” of consumerism, after all, is “purchasers choosing well.”<sup>51</sup> Care-seekers who exercise (consumer) “choice” (especially when footing large bills) face a social imperative to be a “good consumer...which implies a moral judgment” that can be fulfilled through behaviors such as interviewing service providers.<sup>52</sup> Moreover, constitutional protections for “negative” reproductive rights compel governmental inaction, divorcing choice from access and reinforcing market privatization. Our reactions to commodifying ART and abortion may differ, according to whether we feel these contexts are in fact elective, and our perceptions of treatment relationships and providers’ orientation to colleagues and practice areas.

In both ART and abortion, medical culture can subordinate the payment transaction as do other health care contexts, rendering consumption inconspicuous. ART is constructed as more extravagant and private, more “elective” (and “elite”). The stereotypical ART patient, after all, is the well-off older career woman who delayed childbearing.<sup>53</sup> Most care-seekers expect to pay high prices (which may perversely increase ART’s mystique), expect good doctors to be well-paid, and anticipate that clinics will be not merely comfortable, clean, and sanitary but lavish and fashionable. We likely are more comfortable with ART’s commodification so long as it improves care quality, incentivizing goods like quality provider relations and not factory-like treatment experiences.

In contrast to ART, abortion implicates public concerns and public health, lies at the heart of privacy and human rights, and is in wider demand. Because abortion is more stigmatized and yet is a reproductive right, commercial advertising of abortion services, for-profit abortion clinics, high procedure prices, and high provider salaries seem distasteful and more exploitative. Abortion stigma can make abortion seem “dirty,” and many care-seekers are surprised to find abortion clinics clean and sanitary, let alone comfortable.<sup>54</sup> Abortion may then seem more “non-elective” (“non-elite” or secretive), and mainstream culture is less comfortable with abortion commodification, as illustrated by stereotypes of greedy abortion providers and abortion mills as well as advocates’ appeals to safe abortions and decreased stigma.

#### ART AS A MARKET

ART is a market, and market forces shape demand.<sup>55</sup> “Vibrant” fertility clinic websites, buoyant with babies and links to clinic information, treatments, financing, and educational resources allow clinics to reach poten-

tial patients.<sup>56</sup> Paying for ART is also commodified; clinics can offer multi-cycle discounts or refund programs such as “shared risk,” provide in-house financing, or funnel care-seekers to third-party financing firms.<sup>57</sup> Here, too, clinics must keep up with market demands; one clinic felt it needed to extend credit to compete with others, and these arrangements may enhance consumer access and loyalty.<sup>58</sup>

But not all is sunshine and roses; market forces provoke additional criticisms. Patients may be susceptible to doctors’ recommendations, lending terms may be unclear, and doctors may have conflicts of interest if various lenders charge them differently for patient loans.<sup>59</sup> Moreover, ART patients – typically “middle-aged, highly educated, rich, and white” who “usually look like very sophisticated consumers” – may in fact be vulnerable and likely to suffer from depression and desperation, creating “almost inelastic demand.”<sup>60</sup> In addition, ART care-seekers may be “unable to assess the costs of fertility care versus the value of a child.”<sup>61</sup> Finally, it is hard not to wonder about commodification’s effect upon doctor-patient relations after reading a statement such as this one from the “2nd IVF Worldwide Live Congress: A Marketing Wrap-Up” which equates “patients” to “sales”: “Take a 10% conversion rate; meaning – out of every 10 legitimate inquiries you receive, you “close” one sale, you deliver treatments to 1 patient...you know you are converting *at least* 1 out of 10 leads into a real sale, a real patient.”<sup>62</sup>

Scholars worry about decision-making oversight and responsibility. ART and in vitro fertilization (IVF) may function as consumer goods when treatment decisions escape medical oversight, particularly for the uninsured; when care-seekers feel that private payment enables them to choose treatment and control protocols; and when market regulation controls access and raises prices.<sup>63</sup> Criticism within ART warns that cost-conscious patients risk multiple pregnancies, inter-clinic competition and lack of state regulation discourage single-embryo transfers, and clinics deny or downplay market participation.<sup>64</sup> Moreover, the industry places parenthood on a pedestal.<sup>65</sup>

Sociologist Gay Becker pushes beyond commodification to explore how ART care-seekers as consumers negotiate commodification and consumption. ART carries cultural meanings, including identity creation and “hope of motherhood,” and reinforces “strong cultural priorities” such as optimism, autonomy and choice and medical miracles.<sup>66</sup> Becker describes a technological race to the top, where providers pursue novel treatments to satisfy care-seekers’ market-driven expectations.<sup>67</sup> Here, overt commodification is excused; neither ART’s expense nor physician profits may seem inappropriate to care-seekers, given ART’s

“magic” and cultural norms of earning high pay for hard work.<sup>68</sup>

Crucially, however, ART care-seekers are often savvy to the commodification processes. They “often wonder if the...doctors’ motives are primarily medical or lucrative,” whether providers who aggressively recommend IVF are profiteers, and whether ART is “a business which operate[s] on their hopes.”<sup>69</sup> They are “disgusted” by greedy doctors, insulted by “aggressive sales methods,” and deplore “consumerist” indicia like packed waiting rooms, visible counters of patient pregnancies, and providers who do not listen to patients or give individualized treatment plans.<sup>70</sup> In treatment relationships, care-seekers can “exercise control of prices and of obtaining quality products,” and resist the way that ART as a commodified service is offered through skepticism and complaints, even as they continue to undergo treatment and maintain hope.<sup>71</sup> Thus, Becker concludes, care-seekers are a driving consumer force, especially when “defending their own interests, and participate thereby in the redefinition of medical treatments.”<sup>72</sup>

gestational surrogate Crystal Kelley secretly gave birth out-of-state after the intended parents offered her \$10,000 to abort a fetus with birth defects (allegedly, the surrogate initially proposed a \$15,000 counter-offer but rescinded it before fleeing).<sup>78</sup> This example illustrates the various stereotypes of how commodification purportedly affects ART and abortion. Many aspects of ART seem open to market negotiation, but

Despite our discomfort, we cannot ignore the ways in which abortion services function as a market, and how constraints and expansions in abortion access have both had market effects. The abortion market is affected by and in tension with other markets. Women routinely enter markets to access private abortion services. Restricting abortion access can have drastic market effects, but state and market improvements in access and public payment help to de-commodify abortion, reduce its moral, costs and render it more routine.

#### ABORTION AS A MARKET

The commodification of abortion is much more complicated than in ART, and there are few analyses of “abortion markets.” Perhaps this is at least partially because abortion is still seen as a different kind of market. Historically, abortion provision has met with significant resistance. As recently as the 1970s, states criminalized the act of encouraging abortion through lectures, advertisements or other mediums. One early First Amendment advertising case concerning abortion referral service advertisements expressly commodifies abortion, extending protection since no party claimed these messages “related to a commodity or service that was then illegal.”<sup>73</sup> Hospital administrators have feared that abortion could “threaten those types of [private] donations” on which hospitals increasingly rely.<sup>74</sup> Lack of abortion access – a key market factor – has explained why many women have to cross national borders to obtain procedures, and why some countries may punish third parties who would profit accordingly.<sup>75</sup>

Abortion has long been viewed as “dirty work” and positioned as “morally reprehensible,” particularly given “[o]ur silence and polarized moral debates about abortion.”<sup>76</sup> Abortion was certainly marginalized when Joffe researched abortion care work in the late 1970s.<sup>77</sup> Abortion and market concepts remain dangerous bedfellows today; witness the 2013 “Baby S” case, where

abortion is usually construed as a matter of conscience and moral belief. The idea that money could sway a woman from her (assumedly) deep-seated convictions, and that she could respond by demanding a higher price for this compromise seemed preposterous to many. Thus, individuals tread lightly when they speak of abortion “markets”:

[B]uying and selling, entitlement and theft, private and public ownership, owning and disowning, seem not to circulate through the discursive terrain of unwanted pregnancy....This suggests that whatever abortion currently is or means it cannot and does not have anything to do with economy. Further, that it hints at an underlying value judgment: that it should not.<sup>79</sup>

Several reasons likely explain our reticence to speak of abortion “markets.” Perhaps our unease stems from the prominence of altruism in abortion providers’ practice orientations. Numerous providers accept lower earnings and exponentially heightened danger to advance social justice, and frequently speak of their work as a “calling.” ART providers may choose their specialty for altruistic reasons, but face no comparable earnings reduction or danger risk. Moreover, the sharp increase



in organized violence against abortion clinics since the 1980s may make us more hesitant to investigate (and expose, even in academic forums) clinic business practices than in the 1970s. Finally, abortion markets seem somehow more insidious; here, the specter of inequality is more horrifying, and there is wider consensus that health insurance should cover these procedures.<sup>80</sup> We sense that unequal access to abortion affects human flourishing in a different way than within ART.

But despite our discomfort, we cannot ignore the ways in which abortion services function as a market, and how constraints and expansions in abortion access have both had market effects. The abortion market is affected by and in tension with other markets. Women routinely enter markets to access private abortion services. Restricting abortion access can have drastic market effects, but state and market improvements in access and public payment help to de-commodify abortion, reduce its moral, costs and render it more routine.<sup>81</sup>

There is certainly more vocal soul-searching among abortion providers over the allocation of funds and the ethics of a for-profit ethos than among ART providers. Early publications document tensions between business and social welfare models of clinic operation and pricing, the role of providers' private interests, and reliance upon commercial or alternative mediums of promotion.<sup>82</sup>

These tensions have been particularly acute for abortion care workers, who must balance efficiency and humanization and grapple with managerial involvement. Writing of abortion care work today, Todd observes that, although many employees "draw on the caring components of our practice," "our jobs are becoming more rationalized and routinized with an increased emphasis on technical aspects and less of a focus on caring and interpersonal relations."<sup>83</sup> In her memoir, Merle Hoffman, founder, president, and CEO of Choices Women's Medical Center, describes herself as a proponent of "informed medical consumerism" and credits *Roe v. Wade* for initiating the women's health movement and creating "the reality of the female medical consumer."<sup>84</sup> Hoffman reflects upon abortion provision in the 1990s, recalling that almost all clinics charged the same fees (except for "unscrupulous physicians" who charged "illegal immigrant women...unconscionably high rates"), and that she lowered fees for women coming from states with more restrictive abortion laws.<sup>85</sup> Although she found the subject of profits was frequently uncomfortable, commercial success gave her power:

I was the only woman owner of a licensed abortion facility in New York; yet my feminist peers often made me feel as though I was doing some-

thing wrong. Many in the movement felt a real activist should be struggling financially, or at least be working for a nonprofit....I was "making money off the movement"....Money has given me many types of power. With it I have been able to run my clinic the way I want it to be run.... Money has given me the power to support political campaigns and donate to worthy causes.<sup>86</sup>

Moreover, the anti-abortion movement has taken advantage of abortion commodification to inflict damage on abortion services by trying to shut down "markets." During Operation Rescue's protest blockades of one feminist clinic in the late 1980s, "business declined 25, 30 percent."<sup>87</sup> More recently, state regulations — supposedly protective of women — have forced several clinics in embattled states such as Texas and Ohio to close their doors.

Like other consumption sites, abortion can facilitate identity creation and resistance. Women might terminate a pregnancy because they do not want or lack the resources to engage in certain forms of consumption, do not want parental responsibilities, find the pregnancy threatens established relationships, or do not want this particular child. Women can create self-identity by accessing abortion (and perhaps even a particular method) and adapting that lived experience to their needs.

Despite heavy regulation, abortion is still a consumer-driven reproductive market. Clinics respond to specific consumer needs. British clinics have altered services for Irish women; American clinics near the Canadian border set up solicitation and referral systems, advertising, and transportation when Canada outlawed abortion; and American clinics have evolved funding schemes for low-income women.<sup>88</sup> Moreover, clinics' care ethic and women's emotional investments in abortion are also commodified. Clinic advertisements not only highlight compassionate care but explicitly value privacy and convenience; many clinics allow women to pay extra for a shorter wait time, to have support persons with them during the procedure, and even to close the clinic. Non-profit independent clinics may offer women better relational care, prioritizing quality interaction between care professionals and care seekers (e.g., no counseling time limits), but at higher prices. The problem is that reproductive rights supporters want all women to experience these advantages, regardless of socioeconomic status.

### **Commodification, Care Experience, and Reform**

Does consumerism proffer good guidelines for changing health care systems? Though current health care

systems are commodified, they lack the range of choices typical of true consumer markets, and thus health care purchasers do not enjoy the innovation in health care options that a consumer market would bring.

Thus, once more, we encounter “choice” — which we hear much about but enjoy little opportunity to exercise. The appeal of choice within consumer markets is intertwined with self-control. Effective consumer activity is coupled with autonomous personhood.<sup>89</sup> Consumers must both “promote their desires and pleasures” and remain in control of them.<sup>90</sup> To consume in excess is to lose self-control, consumer efficacy, and therefore respect and trust.<sup>91</sup> But as consumer protection efforts recognize, most consumers may have little, if any, sovereign power. Thus, this section will focus on how current consumerist perspectives harm women, whether consumer-driven health care models will bring positive changes, and how such models would impact ART and abortion.

#### *How Current Consumerist Perspectives Shortchange Women*

Normative understandings of consumerism leave women undergoing ART or abortion in an untenable position. If a baby is a “product,” then these women have already “failed” as producers — they either cannot get pregnant and produce the goods, or they produce a pregnancy at the wrong time or without the requisite desire or resources to sustain their child(ren). And they fail as consumers, who are supposed to exercise self-control to gain mastery of themselves, and their (reproductive) desires and products. Sundry arguments have been made that couples undergoing ART are ruled by desperation.<sup>92</sup> Similarly, in pro-life discourse, terminating a pregnancy itself evidences women’s failure as responsible participants in consensual sex, perhaps behaving more as compulsive sexual consumers seeking to evade the consequences of their spree.

In fulfilling their desires to conceive or terminate pregnancy, women in both ART and abortion are supposedly seduced into services with overtones of excess, selfishness, profligacy, and even hedonism — misrepresentations that eliminate socioeconomic disparities in these consumer populations. As services of excess, ART and abortion allegedly trivialize life and degrade personhood. Repeat abortion on demand may be construed as an immoral form of birth control, and continuous rounds of IVF may generate not only multiple pregnancies, but pregnancies of multiples. If “consumer practices considered as ‘normal’ all have in common the fact they are viewed as both the realization of desires and their containment,”<sup>93</sup> then popu-

lar narratives suggest that these women have neither realized their desires (to become pregnant or un-pregnant) nor contained their desires (for procreation or for sexual activity).

Finally, it is significant that these reproductive consumers are mostly women.<sup>94</sup> Females are stereotypically “profligate shoppers,”<sup>95</sup> and representations of their excess and ill-considered choice are cultural mainstays. Moreover, mainstream society does not celebrate autonomous reproductive decision-making as it does other choices, leaving women feeling that that their decisions are stigmatized and silenced. In their reproductive consumption experiences, women may experience a tragic “gap, and even a trade-off, between internal meanings in terms of satisfaction and creativity and external rewards in terms of status and recognition.”<sup>96</sup> In other words, women are not accorded consumer capital for making reproductive choices, even though their consumption experience is thereby enriched. Nor are women given credit for learning how best to effectuate reproductive goals, gaining personal growth, or being effective participants in relations with partners, providers, and others.

#### *Consumer-Driven Health Care to the Rescue?*

This essay solves the patient-consumer debate by focusing not on the patient/consumer dichotomy but on the attributes of which they are comprised. These same experiential attributes also provide guidelines for maximizing the “goods” and minimizing the “harms” within health care relationships and institutions. Whatever health care reforms policymakers choose will presuppose reproductive commodification; in consumer-driven health care, the market is the medium for reform as consumption propels change, and other models alter market health care exchanges by either displacing or facilitating market transactions (e.g., mandating information provision, constraining medical malpractice litigation, etc.). Thus, it is difficult, if not impossible, to find realistic reform solutions that do not presuppose reproductive commodification.

Individuals such as Regina Herzlinger, a foundational figure in the consumer-driven (or consumer-directed) health care (CDHC) movement, know exactly what to do with these attributes: allow care-seekers as consumers to “voice their feelings” and effect change.<sup>97</sup> By itself, commodification is neutral and does not set clear guidelines for structuring reforms. CDHC emphasizes consumer control over health care rather than service providers and “employers and insurers.”<sup>98</sup> Premised on neoclassical economic “rational choice,” CDHC assumes patients “will demand less care if they are burdened with a greater responsibility for pay-

ing the actual cost of that care,” now borne primarily by insurance; here, care-seekers must allocate finite (or scarce) resources between health care and other goods.<sup>99</sup> For Herzlinger, allowing health care “insiders” to guide reform is tantamount to ceding control to a “self-referential intellectual cartel” that quashes innovation out of self-interest.<sup>100</sup>

In CDHC, change is wrought by “an assertive, demanding, knowledgeable group” that voices concerns to industry officials until they respond with innovations.<sup>101</sup> Herzlinger stresses that the system should be organized not by inputs such as “hospitals, doctors, nursing homes, drugs, technology — but by consumer needs.”<sup>102</sup> Yet, she contends, Medicare and private insurers micromanage payment systems, while top-down pricing and care professionals maintain the status quo and retard innovation.<sup>103</sup> A healthy consumer market must have information on consumer satisfaction and care outcomes, even if the government must oversee its collection and dissemination.<sup>104</sup> Deeming the health care industry “insular, self-referential, [and] self-protective,” Herzlinger questions the idea of consumer illiteracy and posits that other third-party providers have embraced this stereotype out of self-protection.<sup>105</sup> Third-party intermediaries could transmute available health care data into forms widely comprehensible and accessible to consumers.<sup>106</sup> But CDHC is unlikely to be implemented, much less succeed, if physicians prioritize profits over patients or discourage those who do.<sup>107</sup>

In CDHC models, therefore, commodification itself paves the way for reform, and experiential qualities could guide change if incorporated into quality measures and reported to consumers. Crucially, this presumes some mechanism of allowing consumers to consistently weigh quality alongside cost and other factors in decision-making; indeed, incentives for evaluating and reporting on patient satisfaction and other quality measures are included within the Patient Protection and Affordable Care Act (ACA).

Moreover, ample evidence suggests patients believe that these experiential qualities are enormously important. In qualitative interviews, ART care-seekers ranked physician bedside manner as extremely important, and a frequent motivation for switching providers. In addition, the Kaiser Foundation’s “National Survey on Americans as Health Consumers” reported that 57% of respondents said that patient reviews of a doctor’s communication skills would tell them “a lot” about a doctor’s quality, ranking fourth below measures such as malpractice suits filed, numbers of procedures performed, and board certification.<sup>108</sup> Moreover, 57% stated that patient reviews of how well a health plan’s doctors communicated would tell

them “a lot” about health plan quality.<sup>109</sup> Incorporating experiential qualities into reform efforts may even increase care-seekers’ acceptance of insurance coverage constraints such as limited provider networks that include “high-quality” providers and exclude those of “low quality or low efficiency.”<sup>110</sup> Finally, care-seekers’ choices would “help us understand the sorts of trade-offs individuals are willing to make.”<sup>111</sup>

We are currently witnessing these very legal and cultural debates play out in the ACA contraception mandate. The United States Supreme Court recently ruled in *Burwell v. Hobby Lobby* that closely-held for-profit corporations were exempt from the Affordable Care Act’s contraception mandate, as it violated their freedoms of conscience and religion.<sup>112</sup> Other mandate opponents contended that taxpayers and employers would be subsidizing their employees’ sexual activities, commodifying sexuality and denigrating women’s dignity.<sup>113</sup> Mandate supporters argued that it protected women’s freedom to make health care decisions and that scrapping it would burden employees that did not share their employer’s beliefs. Therefore, the contraception mandate was a contest over how far the health care market and consumer demand extend, and who could set the terms along which contraceptives are commodified.

*Consumer-Driven Health Care and ART and Abortion* Within ART and abortion, CDHC would have important repercussions. ART more closely approximates a consumer-driven market than abortion, given low insurance coverage and lack of state regulation, making innovation more likely. These days, innovations in abortion amount to contests between novel state restrictions and creative clinic responses. Moreover, if assertive, demanding, and knowledgeable consumers drive market change, then change will favor elite interests. Consumer-driven change would not be democratic; instead, it would likely resemble an inverse oligopoly, a market dominated by a handful of buyers, not sellers. This is unproblematic so long as elite and non-elite interests and interest prioritization align, but these diverse populations likely value and prioritize cost, convenience, and access differently.

Again, this is less of a problem in ART than in abortion, since scarce insurance coverage for fertility treatment produces a less-diverse, elite-dominated consumer base;<sup>114</sup> care-seekers who are poor, poor advocates, or poorly informed can ride the coattails of their elite counterparts. ART care-seekers also have more reform opportunities; care relationships within IVF are more extensive than in abortion, where women make far fewer visits. Switching providers is a realistic option for ART care-seekers,<sup>115</sup> but dissatis-

fied women in abortion have limited recourse, and can only tell others about their experiences and perhaps obtain future procedures elsewhere.

The abortion consumer base is much more diverse;<sup>116</sup> women may not know that they can effect change or have the time or energy to think about it. Due to procedure stigma, population vulnerability, perceived urgency, and visit brevity, these women have fewer reform incentives and opportunities. Thus, reform pressure must come from professional associations or third parties — though states have been the

“shifting altogether to a market commodity.”<sup>120</sup> Thus, Cohen calls for caution when estimating whether state programs (report cards or online databases listing credentials and disciplinary/malpractice records) will successfully increase consumer information access; for Korobkin, CHDC demands “heroically implausible” decision-making ability of consumers facing complex, new and emotional choices.<sup>121</sup> Others are even less optimistic.<sup>122</sup> According to the Kaiser Foundation, one in ten Americans used such information in health care decision-making (though few saw comparative

**The goal of reform is not to provide care-seekers with the freedom to commodify, but the freedom to negotiate commodification. The crucial question will always be who has the power to control the meaning of a commodity, and what respect is accorded alternative and contrasting meanings. Any effective reform model will allow care-seekers to stratify along experiential characteristics in diverse ways, while incentivizing helpful qualities.**

heavyweights in that arena.<sup>117</sup> Usually empowering and equalizing, information can work against choice when state-mandated “informed consent” regimens dispense data linking abortion to future infertility, breast cancer, and mental distress or illness.<sup>118</sup> Here, state regulations displace markets, carving out areas where consumer preferences cannot control.

In ART and abortion, insured and uninsured individuals would likely make very different choices, along the lines of elite versus non-elite needs and preferences. Insured individuals, freed from at least some anxiety over treatment cost, could prioritize relational quality (better care professional — seeker interaction) or greater comfort or convenience. While the uninsured would likely prioritize cost, as private payers they may also enjoy expanded care options from market innovation. Bundling comprehensive women’s health care together in one clinic, however, may ensure that quality reforms are applied to both ART and abortion.

But many doubt that CDHC is the answer to care-seekers’ prayers. For Schneider and Hall, consumerism models are “doomed to disappoint” for several reasons: care-seekers do not match the consumer ideal and may evade choice, providers experience tension between care and financial counseling, and consumer models diminish our responsibility towards others without health care.<sup>119</sup> Moreover, combining “market discipline” and health care is a laudable goal, but “introducing value into the system” is different from

information about health plans, hospitals or doctors), and many that did so either did not need to make a decision then or found the information irrelevant.<sup>123</sup>

Of course, other pathways to reform besides CDHC are possible. Such strategies could be market-displacing, market-facilitating or market-channeling, and led by the government and/or by industry actors.<sup>124</sup> Atul Gawande posits change is spurred by altering physicians’ orientation to each other and to the profession. For example, big health care “chains” could “thrive because they provide goods and services of greater variety, better quality, and lower cost than would otherwise be available,” since vast size provides buying power, centralization, and innovation.<sup>125</sup> Basing payment not only on service or process but outcome and quality creates financial incentives for focusing on clinical performance.<sup>126</sup> Russell Korobkin proposes that government use choice architecture to “facilitate private choices,” helping individuals to make “personally utility-maximizing choices” through “relative value health insurance” covering “medical interventions that meet or exceed a given level of cost-effectiveness.”<sup>127</sup>

These models might be more paternalistic, but paternalism, like commodification, has neutral valence. In this volume, for instance, Swanson documents how Guttmacher shaped abortion and ART laws in the mid-20th century to eliminate the “doctor’s dilemma,” where laws constrained medical treatment.<sup>128</sup> Guttmacher advocated for free choice to give doctors, not patients, greater freedoms in treatment



decision making, but his efforts nevertheless benefited patients.<sup>129</sup> Swanson finds a place for paternalism in medical decision-making because consumer demand may entail “the surrender of professional judgment.”<sup>130</sup>

Regardless of the reform model, ideally the goal will be to create a care system that both is profitable and gives care-seekers what they want. Our willingness to tolerate unequal access to basic health care will likely be a pivotal factor.<sup>131</sup> Crucially, both ART and abortion care could provide models for health care reform in other practice areas. In both contexts, providers are likely to give private payers cost information up front, and interviews with providers suggest that dialogic care models, creation of trust, and informed consent conversations are high priorities.

## Conclusion

The goal of reform is not to provide care-seekers with the freedom to commodify, but the freedom to negotiate commodification. The crucial question will always be who has the power to control the meaning of a commodity, and what respect is accorded alternative and contrasting meanings. Any effective reform model will allow care-seekers to stratify along experiential characteristics in diverse ways, while incentivizing helpful qualities.

Change will not follow from labeling care-seekers as patients or consumers, but from perceiving them as embodied decision makers with unique and even contradictory characteristics, needs and desires. Whether bottom-up or top-down, it is essential that reform leave room for relationality, including therapeutic relations where care-seekers exercise autonomy. Relational approaches have valuable precedent; in *Roe v. Wade*, the abortion decision is ascribed to the woman and her physician, and the ACA gives relationality teeth by incorporating patient satisfaction measures that include provider communication skills. Though markets, like the state, are traditionally “impersonal systems,” care-seekers are demanding something more. Allocating attention to experiential characteristics in reform will help accommodating relationality in health care models, and should prioritize those most in need, not most able to pay.

## References

1. M. A. Hall, “The Legal and Historical Foundations of Patients as Medical Consumers,” *Georgetown Law Journal* 96, no. 2 (2008): 583-597, at 585 n.8.
2. W. G. Pickering, “A Nation of People Called Patients,” *Journal of Medical Ethics* 17, no. 2 (1991): 91-92, at 91.
3. J. Neuberger and R. Tallis, “Do We Need a New Word for Patients?” *British Medical Journal* 318, no. 7222 (1999): 1756-1758, at 1756, 1757. See also Hall, *supra* note 1, at 585.
4. M. A. Hall and C. E. Schneider, “Patients as Consumers: Courts, Contracts and the New Medical Marketplace,” *Michigan Law Review* 106, no. 4 (2008): 643-689, at 688.
5. *Id.*, at 652, 688. See also N. Tomes, “Patients or Health Care Consumers? Why the History of Contested Terms Matters,” in R. A. Stevens, C. E. Rosenberg, and J. R. Burns, eds., *History and Health Policy in the United States: Putting the Past Back In* (New Brunswick: Rutgers University Press, 2006): at 106.
6. See Tomes, *supra* note 5, at 85, 87.
7. *Id.*
8. See Pickering, *supra* note 2.
9. See Neuberger and Tallis, *supra* note 3, at 1756-1757.
10. See Hall, *supra* note 1, at 584; Hall and Schneider, *supra* note 4, at 647. Until recent years, however, health insurance has most often covered “in-network” services and not given care seekers incentives to research health care costs or seek out the least expensive providers.
11. S. R. Herzberg, “Client or Patient: Which Term Is More Appropriate for Use in Occupational Therapy?” *American Journal of Occupational Therapy* 44, no. 6 (1990): 561-564, at 562.
12. J. Loudon et al., “Patients, Clients, Users or Customers: What Should We Call People Attending Sexual Health Services?” *Journal of Family Planning and Reproductive Health Care* 38, no. 1 (2012): 19-22, at 19, 21; see Hall, *supra* note 1, at 584.
13. See Herzberg, *supra* note 11, at 561; G. Annas, *Some Choice: Law, Medicine, and the Market* (New York: Oxford University Press, 1998): at 46.
14. See Tomes, *supra* note 5, at 83.
15. K. J. Arrow, “Uncertainty and the Welfare Economics of Medical Care,” *American Economic Review* 53, no. 5 (1963): 941-73, at 965.
16. See Tomes, *supra* note 5, at 85.
17. See Hall, *supra* note 1, at 585.
18. B. Raphael and B. Emerson, “Are Patients Clients or People?” *Medical Journal of Australia* 154, no. 3 (1991): 183-184, at 184.
19. M. J. Ramdass et al., “Question of ‘Patients’ Versus ‘Clients,’” *Journal of Qualitative Clinical Practice* 21, no. 1-2 (2001): 14-15; P. C. Wing, “Patient or Client? If in Doubt, Ask,” *Canadian Medical Association Journal* 157, no. 3 (1997): 287-280; P. Simmons, “Service User, Patient, Client, User or Survivor: Describing Recipients of Mental Health Services,” *Psychiatrist Online* 34, no. 1 (2010): 20-23; B. R. Nair, “Patient, Client, or Customer?” *Medical Journal of Australia* 169, no. 11-12 (1998): 593; R. McGuire-Snieckus, R. McCabe, and S. Priebe, “Patient, Client or Service User? A Survey of Patient Preferences of Dress and Address of Six Mental Health Professions,” *Psychiatric Bulletin* 27, no. 8 (2003): 305-308.
20. D. Evans, “Commodification,” in D. Southerton, ed., *Encyclopedia of Consumer Culture*, vol. 1 (Thousand Oaks: Sage Publications, 2011): 212-214, at 212; M. Ertman and J. Williams, “Preface: Freedom, Equality, and the Many Futures of Commodification,” in M. Ertman and J. Williams, eds., *Rethinking Commodification* (New York City: New York University Press, 2005): 1-7, at 1.
21. See Evans, *supra* note 20.
22. *Id.*, at 213.
23. Oxford English Dictionary, “Consumption,” available at <<http://www.oed.com/view/Entry/39997?redirectedFrom=consumption#eid>> (last visited April 10, 2015).
24. See Ertman, *supra* note 20, at 2.
25. M. J. Radin, “Market Inalienability,” *Harvard Law Review* 100, no. 8 (1987): 1849-1937.
26. 505 U.S. 833 (1992).
27. See R. B. Siegel, “The Right’s Reasons: Constitutional Conflict and the Spread of Women-Protective Anti-Abortion Argument,” *Duke Law Journal* 57, no. 6 (2008): 1641-1692.
28. Missouri Right to Life, “Missouri House Passes Legislation That Extends Reflection Period to 72 Hours and Requires Parental Notification,” May 13, 2014, available at <<http://missourilife.org/news/2014/2014-03-12.html>> (last visited April 10, 2015).



29. C. E. Hord, "Making Safe Making Safe Abortion Accessible: A Practical Guide for Advocates (IPAS)," available at <<http://www.ipas.org/~media/Files/Ipas%20Publications/AdvocacyGuide.ashx>> (last visited April 10, 2015).
30. D. Schneiderman, "Constitutionalizing the Culture-Ideology of Consumerism," *Social and Legal Studies* 7, no. 2 (1998): 213-238, at 219.
31. *Id.*, at 218-219.
32. J. S. Taylor, *The Public Life of the Fetal Sonogram: Technology, Consumption, and the Politics of Reproduction* (Rutgers: Rutgers University Press, 2008): at 118-119.
33. M. J. Radin and M. Sunder, "Introduction: The Subject and Object of Commodification, in Rethinking Commodification," in *Rethinking Commodification*, *supra* note 20.
34. R. Fletcher, "Legal Form, Commodities and Reproduction: Reading Pashukanis," in M. Drakopoulou, ed., *Feminist Encounters with Legal Philosophy* (New York: Routledge, 2013): at 138-157.
35. K. Krawiec, "The Dark Side of Commodification Critiques: Politics and Elitism in Standardized Testing," *Washington University Journal of Law and Policy* 35 (2011): 349-362, at 350-354; I. G. Cohen, "The Price of Everything, the Value of Nothing: Reframing the Commodification Debate," *Harvard Law Review* 117, no. 2 (2003): 689-710, at 690-691.
36. V. A. Zelizer, *The Purchase of Intimacy* (Princeton: Princeton University Press, 2007): at 22.
37. See Radin, *supra* note 25.
38. E. D. Pellegrino, "The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic," *Journal of Medicine and Philosophy* 24, no. 3 (1999): 243-66, at 252.
39. *Id.*
40. R. Petchesky, "The Body as Property: A Feminist Re-vision," in F.D. Ginsburg and R. Rapp, eds., *Conceiving the New World Order: The Global Politics of Reproduction* (Berkeley: University of California Press, 1995): at 387-406. See also N. Duxbury, "Do Markets Degrade?" *Modern Law Review* 59, no. 3 (1996): 331-348, at 343.
41. See Krawiec, *supra* note 35, at 349-350.
42. See Radin and Sunder, *supra* note 33, at 13; Zelizer, *supra* note 36; D. Satz, *Why Some Things Should Not Be for Sale: The Moral Limits of Markets* (New York: Oxford University Press, 2012): at 11; M. J. Sandel, *What Money Can't Buy: The Moral Limits of Markets* (New York: Farrar, Straus and Giroux, 2012): at 15.
43. M. M. Ertman, "What's Wrong With a Parenthood Market? A New and Improved Theory of Commodification," in *Rethinking Commodification*, *supra* note 20.
44. R. Fletcher, "Reproductive Consumption," *Feminist Theory* 7, no. 1 (2006): 27-47, at 28, 30.
45. See Taylor, *supra* note 32, at 140.
46. I am indebted to I. Glenn Cohen for this observation.
47. K. Krawiec, "Altruism and Intermediation in the Market for Babies," *Washington and Lee Law Review* 66, no. 1 (2009): 203-257, at 241.
48. *Id.*, at 75.
49. R. Sassatelli, *Consumer Culture: History, Theory and Politics* (Thousand Oaks: Sage Publications Inc., 2007): at 115, 142.
50. G. Becker, "Selling Hope: Commercialization and Consumption of the New Reproductive Technologies in the United States," *Sciences Sociales et Sante* 18, no. 4 (2000): 105-126, at 109, 120.
51. C. E. Schneider and M. A. Hall, "The Patient Life: Can Consumers Direct Health Care?" *American Journal of Law and Medicine* 35, no. 1 (2009): 7-65, at 14.
52. See Becker, *supra* note 50, at 116-117.
53. J. Madeira, "Woman Scorned: Resurrecting Infertile Women's Decision-Making Autonomy," *Maryland Law Review* 71, no. 2 (2012): 339-410, at 366.
54. L. Harris et al., "Dynamics of Stigma in Abortion Work: Findings from a Pilot Study of the Providers Share Workshop," *Social Science & Medicine* 73, no. 7 (2011): 1062-1070, at 1062-63.
55. See Krawiec, *supra* note 47, at 213.
56. J. Hawkins, "Selling ART: An Empirical Assessment of Advertising on Fertility Clinics' Websites," *Indiana Law Journal* 88, no. 4 (2013): 1147-1179, at 1149.
57. J. Hawkins, "Doctors as Bankers: Evidence From Fertility Markets," *Tulane Law Review* 84, no. 4 (2010): 841-898, at 843, 849.
58. *Id.*, at 850.
59. *Id.*, at 844.
60. *Id.*, at 873.
61. See Hawkins, *supra* note 56, at 1155.
62. I. Levitan, "IVF Worldwide Blog: The 2nd IVF Worldwide Live Congress: A Marketing Wrap-Up," available at <<http://www.ivf-worldwide.com/ivf-worldwide-blog/the-2nd-ivf-worldwide-live-congress-a-marketing-wrap-up.html>> (last visited April 10, 2015).
63. See Hawkins, *supra* note 56, at 1156.
64. M. Ryan, *Ethics and Economics of Assisted Reproduction: The Cost of Longing* (Washington, D.C.: Georgetown University Press, 2001): at 23-24, 26-27.
65. *Id.*, at 28; Krawiec, *supra* note 47, at 213.
66. See Becker, *supra* note 50, at 106, 107-109, 120.
67. *Id.*, at 110, 112.
68. *Id.*, at 114, 119.
69. *Id.*, at 116.
70. *Id.*, at 117, 119.
71. *Id.*, at 117, 121.
72. *Id.*, at 121.
73. *Bigelow v. Commonwealth of Virginia*, 421 U.S. 809, 828 (1975).
74. S. Todd, "Secrecy and Safety: Health Care Workers in Abortion Clinics," *Labour/Le Travail* 50, (2002): 401-406, at 405.
75. C. Sethna and M. Doull, "Accidental Tourists: Canadian Women, Abortion Tourism, and Travel," *Women's Studies* 41, no. 4 (2012): 457-75, at 461.
76. See Todd, *supra* note 74, at 403, 405.
77. C. Joffe, "Abortion Work: Strains, Coming Strategies, Policy Implications," *Social Work* 24, no. 6 (1979): 485-489, at 486.
78. K. Breighton, "Surrogate Motherhood, Disability, and Abortion in the Case of 'Baby S,'" *Penn Bioethics Journal* VIII, no. ii (2012): 8-9, at 8.
79. K. L. F. Houle, *Responsibility, Complexity, and Abortion: Toward a New Image of Ethical Thought* (Lanham, MD: Lexington Books, 2014): at 86.
80. See S. Roberts et al., "Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States," *Women's Health Issues* 24, no. 2 (March-April 2014): e211-e218.
81. See, e.g., A. Chelstowska, "Stigmatisation and Commercialisation of Abortion Services in Poland: Turning Sin into Gold," *Reproductive Health Matters* 19, no. 37 (2011): 98-106; A. Wolfe, *Whose Keeper? Social Science and Moral Obligation* (Berkeley: University of California Press, 1989): at 240.
82. H. S. Gitlow, "Abortion Services: Time for a Discussion of Marketing Policies," *Journal of Marketing* 42, no. 2 (1978): 71-82, at 72; K. Garbarino et al., *The Abortion Business: A Report on Free-Standing Abortion Clinics* (Cambridge, MA: Women's Research Action Project, 1975).
83. See Todd, *supra* note 74, at 405.
84. M. Hoffman, *Intimate Wars: The Life and Times of the Woman Who Brought Abortion from the Back Alley to the Boardroom* (New York: Feminist Press at CUNY, 2012): at 82.
85. *Id.*, at 183.
86. *Id.*, at 184.
87. W. Simonds, *Abortion at Work: Ideology and Practice in a Feminist Clinic* (New Brunswick: Rutgers University Press, 1996): at 108.
88. R. Fletcher, "Reproductive Consumption: Adapting British Abortion Services to Irish Women's Needs," Presentation at the Annual Meeting of the Law and Society Association (May 27, 2004), available at <[http://citation.allacademic.com/meta/p\\_](http://citation.allacademic.com/meta/p_)

- mla\_apa\_research\_citation/1/1/7/0/6/p117062\_index.html?hpssid=6nfu69vna6a7t4du8q7s866nc2> (last visited April 10, 2015); A. Whittaker and A. Speier, "Cycling Overseas: Care, Commodification, and Stratification in Cross-Border Reproductive Travel," *Medical Anthropology* 29, no. 4 (2010): 363-383.
89. See Sassatelli, *supra* note 49, at 154.
  90. *Id.*, at 154, 156.
  91. *Id.*, at 156.
  92. See Madeira, *supra* note 53.
  93. See Sassatelli, *supra* note 49, at 156-157.
  94. *Id.*, at 160.
  95. *Id.*
  96. *Id.*, at 197.
  97. R. S. Galvin, "Consumerism and Controversy: A Conversation with Regina Herzlinger," *Health Affairs* 26, no. 5 (2007): 552-59, at 553.
  98. See K. Madison and P. D. Jacobson, "Consumer-Directed Health Care," *University of Pennsylvania Law Review PEN-Numbra* 156, (2007): 107-25, at 108, available at <<http://www.pennlawreview.com/online/156-U-Pa-L-Rev-PENNumbra-107.pdf>> (last visited April 18, 2015).
  99. R. Korobkin, "Comparative Effectiveness Research As Choice Architecture: The Behavioral Law and Economics Solutions to the Health Care Cost Crisis," *Michigan Law Review* 112, no. 4 (2014): 523-574, at 525.
  100. See Galvin, *supra* note 97, at 559.
  101. *Id.*, at 553.
  102. *Id.*, at 554.
  103. *Id.*, at 554-555.
  104. *Id.*, at 556-557.
  105. *Id.*, at 557.
  106. *Id.*, at 557.
  107. A. Gawande, "Big Med," *The New Yorker*, August 13, 2012, available at <[http://www.newyorker.com/reporting/2012/08/13/120813fa\\_fact\\_gawande?currentPage=all](http://www.newyorker.com/reporting/2012/08/13/120813fa_fact_gawande?currentPage=all)> (last visited April 10, 2015).
  108. The Kaiser Family Foundation and Agency for Health Care Research and Quality, *National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information* (2000): at Chart 4: Doctor Quality, available at <<http://archive.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/kffupdate/kffchartbk00.pdf>> (last visited April 18, 2015).
  109. *Id.*, at Chart 7: Other Indicators of Health Plan Quality.
  110. See Madison and Jacobson, *supra* note 98, at 111.
  111. *Id.*, at 112.
  112. 573 U.S. \_\_\_\_ (2014) (Hobby Lobby case).
  113. See, e.g., D. Philpott, "Why Christians Cannot Just 'Lighten Up' over the HHS Mandate," Religious Freedom Project, Berkley Center for Religion, Peace & World Affairs, available at <<http://berkleycenter.georgetown.edu/essays/why-christians-cannot-just-lighten-up-over-the-hhs-mandate>> (last visited April 18, 2015).
  114. M. Bitler and L. Schmidt, "Health Disparities and Infertility: Impacts of State Level Insurance Mandates," *Fertility and Sterility* 85, no. 4 (2006): 858-865; E. H. Stephen and A. Chandra, "Use of Infertility Services in the United States: 1995," *Family Planning Perspectives* 32, no. 3 (2000): 132-137.
  115. See A. Domar et al., "A Prospective Investigation into the Reasons Why Insured United States Patients Drop Out of In Vitro Fertilization Treatment," *Fertility & Sterility* 94, no. 4 (September 2010): 1457-1459.
  116. See Guttmacher Institute, "Characteristics of Women Having Abortions," available at <<http://www.guttmacher.org/in-the-know/characteristics.html>> (last visited April 10, 2015) (reporting that women with family incomes below the federal poverty level account for more than 40% of abortions, whereas those with incomes 200% above the poverty line have abortions at half the national rate).
  117. See Guttmacher Institute, "State Policies in Brief: An Overview of Abortion Laws," available at <[http://www.guttmacher.org/statecenter/spibs/spib\\_OAL.pdf](http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf)> (last visited April 10, 2015).
  118. See Guttmacher Institute, "State Policies in Brief: Counseling and Waiting Periods for Abortion," available at <[http://www.guttmacher.org/statecenter/spibs/spib\\_MWPA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf)> (last visited April 10, 2015).
  119. See Schneider and Hall, *supra* note 51.
  120. See Madison and Jacobson, *supra* note 98, at 115.
  121. I. G. Cohen, "Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument," *Iowa Law Review* 95, no. 5 (2010): 1467-1567, at 1507-1508.
  122. See Schneider and Hall, *supra* note 51; Korobkin, *supra* note 99, at 531-538.
  123. See Kaiser Family Foundation, *supra* note 108.
  124. See K. Madison, "Regulating Health Care Quality in an Information Age," *U.C. Davis Law Review* 40, no. 5 (2007): 1577-1654.
  125. See Gawande, *supra* note 107.
  126. See Galvin, *supra* note 97, at 557-558.
  127. See Korobkin, *supra* note 99, at 527.
  128. K. Swanson, "The Doctor's Dilemma: Paternalism in the Medicolegal History of Assisted Reproduction and Abortion," *Intersections in Reproduction: Perspectives on Abortion, Assisted Reproductive Technologies, and Judicial Review*, Program for the Study of Reproductive Justice, Yale Law School, April 2014.
  129. *Id.*
  130. *Id.*
  131. See Madison and Jacobson, *supra* note 98, at 124.